U.S. Department of Labor

Office of Administrative Law Judges
525 Vine Street - Suite 900
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue date: 13Feb2001

Case No: 1999-LHC-1943

In the Matter of

CESAR TORRES,
Claimant

v.

CONTINENTAL MARITIME INDUSTRIES,
Employer

MAJESTIC INSURANCE COMPANY,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Jeffrey M. Winter, Esquire
For the Claimant

Maryann C. Shirvell, Esquire
For the Employer/Carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — DENYING BENEFITS

This proceeding arises from a claim for workers' compensation benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901 *et seq.* (hereinafter "the LHWCA" or "the Act"). Mr. Torres filed a claim for compensation under the Act on January 6, 1997. Continental Maritime Industries and its insurer, Majestic Insurance Company (hereinafter referred to collectively as "the Employer"), timely controverted Mr. Torres' right to compensation on January 14, 1997. The District Director referred this case to the Office of Administrative Law Judges on May 6, 1999. Following proper notice to all parties, a formal hearing was held in full accordance with the Administrative Procedure Act, 5 U.S.C. § 500, *et seq.*, on December 16, 1999 in San Diego, California. Claimant's Exhibits 1-15 and Employer's Exhibits A-V were admitted into evidence at the hearing pursuant to 20 C.F.R. § 702.338. The Director did not submit any exhibits at the hearing. The parties were afforded an opportunity to present testimonial evidence and either closing arguments or post-hearing briefs. The Claimant submitted a post-hearing brief on February 22, 2000. The Employer submitted its post-hearing brief on the same day.[1]

The parties have stipulated to the following issues: the Act applies to this claim; the claim was timely filed, noticed and controverted; the Claimant's average weekly wage at the time of the alleged injury was $485; the Employer is entitled to a $1,250 credit under § 3(e) of the Act due to the Claimant's settlement with Pacific Ship Repair and Fabrication, Incorporated; and, in the event the Claimant's alleged injury is found to be compensable, the Claimant's residual earning capacity would be $400 per week from March 7, 1996 through April 30, 1996; $404 per week from May 1, 1996 through May 31, 1996; and $421.20 per week from June 1, 1996 through July 31, 1996. (Tr. 6-7). The following issues remain for adjudication: (1) whether Mr. Torres suffered from an injury arising out of and in the course of employment; (2) the identity of the last responsible employer; (3) the amount of any interest owed on past due benefits; and (4) whether Mr. Torres was permanently and totally disabled from July 28, 1995 through March 6, 1996. *Id.* at 7.

FINDINGS OF FACT

Cesar Torres began working as a painter in 1986. (Tr. 33). He obtained employment with Continental Maritime Industries (hereinafter "Continental" or "the Employer") in 1992. Approximately six months after beginning his employment with Continental, the Claimant

[1]Citations to Tr., CX, DX, EX, and JX in this opinion refer to the official hearing transcript, the Claimant's Exhibits, the Director's Exhibits, the Employer's Exhibits, and Joint Exhibits, respectively.

began experiencing shortness of breath and rapid heartbeats. *Id.* at 17. He first experienced these symptoms while traveling to work. *Id.* at 39. Mr. Torres testified that when he arrived at work, he was taken to a doctor and did not work that day. *Id.* at 40.

The oldest medical records in evidence indicate the Claimant drove himself to the Emergency Room of the Community Hospital of Chula Vista, California on February 14, 1993 because he was suffering from chest pain and abdominal pain. (EX E). Dr. Mark Shaffer, the physician who treated Mr. Torres, noted Mr. Torres' symptoms had been present for approximately three months. Dr. Shaffer described the Claimant's symptoms as "chest pain characterized by regurgitation, a burping-type sensation, and heartburn associated with gastric distention, and epigastric pain." The physician stated Mr. Torres came to the emergency department not because his symptoms had worsened but because he wanted his symptoms "treated definitively." A gastrointestinal cocktail was administered to Mr. Torres. Dr. Shaffer diagnosed the Claimant with gastritis and an esophageal spasm. No shortness of breath or rapid heartbeat were noted. After his February 1993 visit to Community Hospital, Mr. Torres was evaluated by a number of physicians who tried to determine the source of his symptoms.

Dr. Reuben Farris referred the Claimant to Dr. Gregory Wiener. (EX E). In a March 3, 1993 letter, Dr. Wiener noted Mr. Torres was suffering from "noncardiac chest pain, anxiety, questionable bulimia, and weight loss with dysphagia." Dr. Wiener performed an endoscopy on Mr. Torres and concluded Mr. Torres suffers from mild esophagitis and an esophageal motility disorder. Dr. Wiener diagnosed a hypersensitive esophagus because the Claimant's symptoms improved when he placed the Claimant on Prilosec and Reglan. The physician noted Mr. Torres had problems with anxiety and shaking after drinking beverages with a lot of sugar. Dr. Wiener recommended a five-hour glucose test to rule out hypoglycemia; however, the physician doubted the Claimant suffered from such a condition.

In a March 16, 1993 letter to Dr. Farris, Dr. Wiener again noted an ultrasound and endoscopy of the Claimant's abdomen revealed an esophageal motility disorder and very mild esophagitis. Dr. Wiener commented the endoscopy "in general, was quite benign compared to [Mr. Torres'] apparent symptoms. (EX R). It was clear to Dr. Wiener that Mr. Torres probably suffers from somatic complaints secondary to anxiety or depression. Dr. Wiener opined the Claimant may suffer from a thoracic spine or cervical spine compression or nerve entrapment secondary to his job. The physician viewed Mr. Torres as a "very difficult patient to take care of" because he does not want psychological help, which Dr. Wiener thought is the "crux " of Mr. Torres' problems. Dr. Wiener found no organic cause for the Claimant's chest pains and asked the Claimant to return to Dr. Farris in addition to having a neurological and psychological evaluation. The physician stated Mr. Torres refused his referral for a psychological evaluation, but Mr. Torres did agree to submit to a neurological evaluation by Dr. Stephen Stecker. *Id.* An x-ray of Mr. Torres' chest was taken on April 20, 1993. (EX H). Dr. John Wells interpreted the x-ray as normal.

Dr. Stecker examined the Claimant on October 5, 1993. (EX R). The physician diagnosed cervical, thoracic, and suprascapular pain on the right with substernal chest pain and found no evidence of cervical radiculopathy. Dr. Stecker stated polymyalgia, chest or esophageal disease, and arthritic changes in the right shoulder joint needed to be ruled out as possible diagnoses.

Mr. Torres testified he began to think his shortness of breath and rapid heartbeat were somehow related to his work as a painter about half way through his employment at Continental. (Tr. 18). Mr. Torres stated he experienced "episodes" which he felt required medical attention three times each week during the latter part of his employment with Continental. *Id.* at 21. Employment records from Continental indicate Mr. Torres was absent from work on at least six occasions, only one of which the Claimant attributed to personal illness. (EX H). The records also indicate Mr. Torres passed a respirator fit test on October 6, 1994. *Id.* On October 27, 1994, Mr. Torres underwent an annual painter's examination at Continental. *Id.* The examination included a basic physical examination, a pulmonary function study, sputum cytology, blood urea nitrogen, and a creatinine and stool occult blood test. The physician conducting the examination noted Mr. Torres had a history of a nervous stomach and a nervous disorder. The physician found Mr. Torres was physically and psychologically capable of performing all four job classes, which included administrative work, clerical and/or light physical work, moderate physical activity, and work involving heavy stress on one's back. As part of the examination, Mr. Torres also completed a Periodic Medical Questionnaire. On the questionnaire, the Claimant stated his job as a painter involved mild dust exposure and mild exposure to gas or chemical fumes. Mr. Torres also stated that if he gets a cold, it usually goes to his chest and results in phlegm production. The Claimant indicated he was a nonsmoker and consumed alcohol approximately once per month. Mr. Torres stated he had suffered from fatigue, frequent headaches, heartburn, and insomnia in the twelve months prior to the examination. The Claimant did not indicate he had been experiencing chest pain although the symptom was listed on the questionnaire. When asked whether he had ever worked at a job in which he noticed changes in his ability to breathe, or increased incidences of coughing, sneezing, or chest colds, the Claimant replied "no." Mr. Torres also stated that when he works around ammonia his nose runs and his sinuses become congested.

Throughout the remainder of his employment with Continental, Mr. Torres sought emergency treatment on two occasions and visited Dr. Carlos de Carvalho on two occasions. Mr. Torres visited the Emergency Room of Scripps Memorial Hospital in Chula Vista, California twice during May 1995 for problems unrelated to the symptoms Mr. Torres now attributes to his employment with Continental. On May 5, 1995, Dr. Wayne Bergman treated the Claimant for abdominal pains and nausea. (EX C). Dr. Bergman treated Mr. Torres again on May 12, 1995 for a contusion of the scalp. *Id.* During the second visit, Dr. Bergman noted the Claimant has a history of psychiatric problems, specifically anxiety and depression.

Dr. Carlos de Carvalho treated the Claimant from May 18, 1995 through June 23, 1997. (EX F). The physician treated Mr. Torres twice before Mr. Torres left his employment with Continental.

Dr. de Carvalho treated Mr. Torres on May 18, 1995 for the head injury Dr. Bergman initially treated, a condition which was unrelated to Mr. Torres' employment. Dr. de Carvalho also diagnosed acute gastritis during the May 18, 1995 visit. The physician's records indicate the Claimant was suffering from chest pain and night sweats with "often panic disorder" and fatigue. On June 1, 1995, Dr. de Carvalho examined the Claimant and diagnosed paroxysmal atrial tachycardia. The physician commented Mr. Torres "may need to see a psych. soon." Mr. Torres' employment with Continental ended on June 2, 1995 when he was laid off in connection with a reduction in work force. (EX H).

After being laid off from Continental, Mr. Torres began working as a painter for Pacific Ship & Repair, Incorporated (hereinafter "Pacific") on June 27, 1995. (EX D). Mr. Torres' job duties were the same at Pacific as they were at Continental. (Tr. 32). According to the Claimant, his job at Pacific "aggravated" his breathing and he had more difficulty breathing, chest pains, and dizziness during his employment at Pacific. *Id.* at 34. The Claimant testified he had to stop working at Pacific on more than one occasion due to his breathing problems. *Id.* at 22. Mr. Torres stated his symptoms became so severe at Pacific that he had to stop working in the shipyards. *Id.* at 34. Mr. Torres was laid off from his job at Pacific on July 14, 1995. (EX D). Thereafter, Mr. Torres filed a claim under the Act against Pacific which settled during January 1997. (Tr. 39)(EX D).

On July 19, 1995, Dr. Alex Han prepared a First Report of Occupational Injury on Mr. Torres in connection with Mr. Torres' claim against Pacific. (EX D). The report indicates Mr. Torres' injury occurred while he was painting when he started having sick stomach pains, headaches, and nervousness. The Claimant was complaining of headaches, sharp chest pains, palpitations, fatigue, increased cough, and nausea. On physical examination, Dr. Han found Mr. Torres to be alert. A neurovascular examination was negative. Dr. Han stated the Claimant's chest x-rays were pending and that he needed to rule out toxic fume syndrome. (EX D)(CX 5). Dr. Han also administered an electrocardiogram, pulmonary function testing, depo-medrol, and tri-fedrine. The physician concluded Mr. Torres was not able to perform his usual work at that time, but could return to modified work on July 20, 1995. The pending chest x-ray dated July 19, 1995 was interpreted by Dr. C.D. Lee as normal. (EX D).

Dr. de Carvalho's records do not indicate he treated Mr. Torres during Mr. Torres' employment with Pacific; however, the physician did treat Mr. Torres after his employment with Pacific ended on July 18, 1995. (EX F). During July 28, 1995 and August 1, 1995 visits to Dr. de Carvalho, Mr. Torres was diagnosed with acute gastroenteritis. On August 15, 1995, Dr. de Carvalho diagnosed the Claimant with a panic disorder in addition to acute gastroenteritis. The physician treated Mr. Torres for an acute chest trauma on October 21, 1996. On November 11, 1996, Mr. Torres went to Dr. de Carvalho complaining of palpitations. Dr. de Carvalho again diagnosed Mr. Torres with paroxysmal atrial tachycardia and panic disorder. The physician commented Mr. Torres "may need to see a psych. soon." On June 23, 1997, Dr. de Carvalho diagnosed the Claimant with acute gastritis. The physician recommended Mr. Torres avoid spicy, greasy, and corrosive foods and caffeinated drinks. Dr. de

Carvalho commented that Mr. Torres "got upset because [the physician] told him to do this instead of sending him to see a specialist."

On June 27, 1995, Mr. Torres' first day of work at Pacific, Mr. Torres was examined by an unidentified physician. (CX 5). The physician noted a history of seizures, fits, convulsions or fainting, and a nervous stomach. The physician stated Mr. Torres was suffering from panic attacks and was prescribed Xanax for his nervousness and Donnatal for his stomach problems. A Medical Restrictions and Limitations Examination Report dated June 27, 1995, from the South Coast Medical Clinic in National City, California, indicates an unnamed physician examined Mr. Torres and found him to be physically and psychologically capable of "all four job classes." (EX D).

On August 23, 1995, Mr. Torres selected Dr. James Lineback as his treating physician and Dr. Lineback completed a document entitled "Doctor's First Report of Occupational Injury or Illness." (CX 8)(EX M). Dr. Lineback is board-certified in internal medicine and pulmonary medicine. Dr. Lineback described Mr. Torres' exposure as "toxic fume inhalation →fatigue and shortness of breath." Mr. Torres was complaining of shortness of breath and fatigue. Dr. Lineback offered no physical examination findings and the x-ray and laboratory results were pending. No treatment was rendered pending the results of the diagnostic testing. The physician opined the Claimant was not able to perform his usual work, but made no determination as to when the Claimant could return to work. Dr. Lineback simply stated "?pending testing."

A letter from Dr. Hano Siegel addressed to Dr. Lineback indicates Mr. Torres underwent an upper gastrointestinal series on August 24, 1995 which was normal. (EX Q). Medical records from Dr. Lineback dated August 1995 indicate Mr. Torres was suffering from rapid heartbeat, gastrointestinal upset, headaches, and nervous problems/panic attacks. The physician concluded the Claimant was no longer able to work around paint fumes. According to Dr. Lineback, Mr. Torres underwent testing at the Comprehensive Medical Center to determine his chemical exposure. The physician stated the Claimant was told the fillings in his mouth might be the cause of his problems, so the Claimant had his dentist remove the fillings.

On September 3, 1995, Dr. Lineback examined the Claimant and documented the Claimant's medical history. (CX 10). Dr. Lineback stated Mr. Torres began experiencing chest pains, shortness of breath, easy fatigue, a chronic cough, and gastrointestinal upset in October 1992 while working for Continental. According to Dr. Lineback, the symptoms persisted over the course of the next three years. Mr. Torres' symptoms would improve once he left his job as a painter and would increase in severity when he returned to his job as a painter. The physician stated Mr. Torres had been exposed to continuous paint fumes while painting in space tanks on ships during his employment with both Continental and Pacific. Dr. Lineback noted Mr. Torres' employers provided him with a respirator, but stated the cartridges wore out occasionally. Mr. Torres alleged he would "often be confined in [the

space] tanks for several hours without adequate ventilation." Dr. Lineback noted the Claimant was allergic to paint strippers, cleaners, thinners, reducers, and epoxies.

Dr. Lineback's physical examination of the Claimant's chest revealed no wheezes, rales, or rhonchi on auscultation. Dr. Lineback also noted tenderness in the Claimant's abdomen and costo vertebral tenderness or rigidity. During the examination, Dr. Lineback reviewed material data safety sheets pertaining to Proline 1220. According to the physician, the sheets advised the use of a respirator with a high efficiency cartridge. The documents also provided that if Proline 1220 is inhaled, the vapors can cause headache, dizziness, stupor, nausea, and vomiting. The documents warned that "chronic exposure [could] result in elevated carboxyhemoglobin levels in patients exposed to methylene chloride [and could] cause a substance stress on the cardiovascular system."

During the September 3, 1995 examination, Dr. Lineback diagnosed Mr. Torres with palpitations, persistent nausea, shortness of breath, easy fatigue, and abdominal pain. The physician opined the Claimant was temporarily totally disabled. Dr. Lineback scheduled Mr. Torres for an upper gastrointestinal study because the Claimant continued to voice gastrointestinal complaints even though he was being treated with a number of medications. The physician also wanted to review the Claimant's medical records from Mercy Hospital, from the Claimant's cardiologist's office, and from Dr. Jeffrey Mullvain. Dr. Lineback intended to formulate a treatment plan for Mr. Torres after reviewing the medical records and the results of the upper gastrointestinal study. The physician instructed Mr. Torres to continue taking the medications he had been taking for the past several months.

A September 27, 1995 interim report prepared by Dr. Lineback indicates the longshoreman continued to suffer from shortness of breath and that an upper gastrointestinal series was within normal limits. *Id.* Dr. Lineback diagnosed shortness of breath and abdominal pain and opined the Claimant was temporarily totally disabled. The physician planned to request Mr. Torres' medical records again and order a pulmonary function study. Dr. Lineback told the Claimant to return to the clinic in four weeks for another examination.

Dr. Lineback saw the Claimant again on October 25, 1995. (CX 10). The physician noted the Claimant's condition was the same and stated pulmonary function studies had not yet been conducted. Dr. Lineback diagnosed abdominal pain, palpitations, and shortness of breath. The physician planned to proceed with the pulmonary function testing and wanted Mr. Torres to return to his office for a follow-up visit in one month. During a November 21, 1995 visit, Dr. Lineback noted Mr. Torres' condition was the same and diagnosed abdominal pain, shortness of breath, and palpitations. The physician planned to prescribe Donnatol and to have Mr. Torres undergo pulmonary function tests. On December 20, 1995, Mr. Torres returned to Dr. Lineback's office for a follow-up visit. The physician noted the Claimant's condition was improving. Dr. Lineback diagnosed irritable

bowel syndrome, shortness of breath, palpitations, and headaches. During a January 17, 1996 visit, Dr. Lineback noted Mr. Torres' condition was still improving and that the Claimant's shortness of breath was gradually improving. Pulmonary function studies still had not been administered. The physician again diagnosed abdominal pain and shortness of breath. During each of the Claimant's visits to Dr. Lineback from September 27, 1995 through January 17, 1996, Dr. Lineback opined the Claimant was temporarily totally disabled.

Mr. Torres underwent an acute abdominal series on November 8, 1995. (CX 9). A chest x-ray taken as part of the series showed mild left basilar atelectasis and a minimally nonspecific bowel gas pattern.

Dr. Jerrold Glassman examined Mr. Torres on November 30, 1995. (CX 12). Dr. Glassman noted the Claimant had "multiple complaints in multiple areas" and stated "it's hard to separate how much is real." Dr. Glassman noted Mr. Torres stopped smoking three and one-half years prior to the examination and seldom consumed alcoholic beverages. The physician found the miner had gained weight and was suffering from chills, night sweats, headaches, visual disturbances, a chronic, recurrent cough, occasional palpitations, shortness of breath at rest but not with exertion, difficulty swallowing, and nocturia. On physical examination, Dr. Glassman noted the Claimant's chest was clear to auscultation and percussion. Mr. Torres' heart was regular without murmurs or gallops and his abdomen was soft, obese, nontender, and without organomegaly, masses or nodes. No laboratory tests were conducted. The physician diagnosed Mr. Torres with abdominal pain of an unknown etiology and chest pain of an unclear etiology. Dr. Glassman also diagnosed mild obesity and possible anxiety neurosis and panic attacks. The physician noted the Claimant had no evidence of organic disease or coronary artery disease. Dr. Glassman stated Mr. Torres reported having multiple workups by a number of physicians during the three years prior to Dr. Glassman's examination. The physician stated the Claimant has not been found to have any significant organic disease, but acknowledged such findings do not mean a cause is not there that simply has not yet been discovered. Nevertheless, Dr. Glassman opined Mr. Torres' activities should not be restricted and stated the Claimant has the exercise capacity of a normal male of the Claimant's age and height. The physician opined the Claimant has no
restriction from lifting weights, working at heights, or fine manipulation and is able to sit, stand, and work for eight hours a day. Dr. Glassman further opined Mr. Torres is able to return to work and perform all of his duties without restriction.

The Claimant was employed by Steven P. Rados, Incorporated (hereinafter "Rados") during 1996 and 1998. (EX L). Mr. Torres worked at Rados on two occasions for a total of approximately four years. (Tr. 13). Mr. Torres also worked for Mallcraft Construction as a carpenter between his two periods of employment with Rados. *Id.* at 11. According to Dr. Richard Armour, the Claimant was being treated for some type of injury on March 24, 1998 which rendered him unable to return to

work until March 26, 1998. Mr. Torres also sustained a face injury on April 15, 1998 while working for Rados.

The Claimant was employed by Berry Contractors from February 25, 1997 through August 22, 1997. (EX O). Thereafter, Mr. Torres began working at E. L. Yeager as a carpenter, a position which he had held for approximately three weeks at the time of the December 1999 hearing. (Tr. 16). Mr. Torres testified his condition improved after he stopped working in the shipyards during July 1995. *Id.* at 21. He has not been exposed to any toxic fumes, chemicals, or solvents since his employment with Pacific. *Id.* at 11. While working as a carpenter, Mr. Torres saw no doctors in 1997 and had only one episode in both 1998 and 1999 where he thought he needed medical attention. *Id.* at 20-21. At the time of the hearing, the Claimant was not taking any medication for shortness of breath or rapid heartbeat. *Id.* at 22. Mr. Torres does not believe any of the medications prescribed to him or the treatment provided to him have helped him overcome his shortness of breath. *Id.* at 20.

Dr. William Hughson examined Mr. Torres on January 25, 1996 and reviewed extensive medical evidence of record. (CX 13). Dr. Hughson is board-certified in internal medicine,

pulmonary medicine, and occupational medicine. Dr. Hughson noted Mr. Torres was "quite anxious" during the interview and "at various points during the interview," Mr. Torres began flipping through the medical records on Dr. Hughson's desk. The physician stated the Claimant "apologized for this, but had a compulsion to review the stack of records." At the time of Dr. Hughson's examination, Mr. Torres complained of rapid heartbeat which he stated began in 1992. The Claimant also reported "panic attacks" marked by anxiety, nervousness, headaches, exacerbation of stomach discomfort, and rapid heart rate. Mr. Torres stated he suffered from dyspnea while anxious and nervous. Dr. Hughson stated the Claimant smoked cigarettes at
age 20 at the rate of two to four cigarettes per day. Mr. Torres quit for several years and then resumed smoking. The Claimant stated he stopped smoking again in 1992. Mr. Torres also reported drinking alcoholic beverages occasionally as a method of relaxation.

According to Dr. Hughson, Mr. Torres denied shortness of breath on exertion, regular cough, sputum production, wheezing, a history of asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis, coccidioidomycosis, or fractured ribs. Dr. Hughson's review of the Claimant's cardiovascular system revealed a history of "rapid heart beats," but no history of hypertension, angina, myocardial infarction, stroke, or circulatory problems. Dr. Hughson also discussed Mr. Torres' employment history in detail. The physician stated Mr. Torres worked at Continental from May 1992 until June 2, 1995. His job involved paint preparation work including sandblasting, sanding, and grinding, as well spray painting with epoxies and enamels. The Claimant alleged he was exposed to lead paint while doing preparation work. Mr. Torres used a forced-air respirator while painting in tanks and other enclosed areas. The Claimant also used a canister respirator on some occasions, but alleged that the canisters would become clogged and Continental would refuse to replace them which

would "force" the Claimant to inhale paint fumes. Mr. Torres also stated he was laid off from his job at Continental on June 2, 1995 in connection with a reduction in work force; however, Mr. Torres felt he was laid off because he had been "complaining of health problems." Mr. Torres also reported to Dr. Hughson that he worked for Pacific from June 25, 1995 through July 15, 1995. The Claimant voiced complaints about the air quality at Pacific when he was using a canister respirator. Mr. Torres stated he stopped work on July 15, 1995 because he "couldn't take it any more." The Claimant was laid off from Pacific on July 18, 1995.

Dr. Hughson examined Mr. Torres and reviewed extensive medical evidence of record. The Claimant's lungs were clear to inspection, palpation, percussion, and auscultation. No rales, rhonchi, or expiratory wheezes were noted. The Claimant's heart sounds were normal with no extra heart sounds or murmurs. Peripheral pulses were present symmetrically and no bruits were heard. Dr. Hughson also reviewed United States Department of Labor records and medical records from Dr. Lineback, Dr. de Carvalho, Dr. Wiener, Dr. Mullvain, Dr. Farris, Continental, Paradise Valley Hospital, and Scripps Memorial Hospital. Dr. Hughson learned that Mr. Torres underwent a heart catheterization on July 11, 1994, which was normal except for a comment regarding the presence of "very mild pulmonary hypertension." The physician stated Mr. Torres "may have primary pulmonary hypertension or possibly chronic thromboembolic disease," but stated neither of the conditions were related to his employment at Pacific.

After reviewing the documentary evidence of record, Dr. Hughson commented that "considering [Mr. Torres'] age, [he] has had quite a remarkable series of investigations to determine the cause of his complaints." Dr. Hughson noted Mr. Torres had a long history of anxiety and panic attacks associated with his physical complaints. The physician concluded the medical records of Drs. Wiener and Mullvain establish that the Claimant suffers from mild esophagitis, esophageal motility disorder, and possible mild pulmonary hypertension. Dr. Hughson noted several other physicians referred to anxiety and panic disorders, but that Mr. Torres had refused referrals for psychological or psychiatric evaluations. Dr. Hughson "strongly suspect[ed]" the basis for most of Mr. Torres' physical complaints were psychological or psychiatric problems. Dr. Hughson was concerned that Mr. Torres may suffer from claustrophobia aggravated by the use of a respirator or work in confined spaces. The physician noted "approximately 10% of the people who are evaluated for respirator use cannot use those devices because of claustrophobia." The physician found no basis for a diagnosis of a pulmonary condition, noting multiple pulmonary function tests were within normal limits. Dr. Hughson believed Mr. Torres' condition will not improve until he addresses the issue of psychological or psychiatric problems and receives appropriate evaluation and treatment. The physician opined he does not believe the Claimant's symptoms are related to his employment at Pacific and noted all of Mr. Torres' health problems were present during his employment with Continental. Dr. Hughson thought the most important medical treatment Mr. Torres can receive is to be evaluated by a psychiatrist or psychologist. The physician expressed concern that the Claimant may be suffering from claustrophobia or "some other type of primary psychiatric problem."

Dr. Hughson stated Mr. Torres had already undergone extensive gastrointestinal and cardiac evaluations. The physician concluded the Claimant's esophageal mobility and mild esophagitis should be treated on a non-industrial basis because they were not affected by his brief employment at Pacific. Dr. Hughson questioned the diagnosis of pulmonary hypertension because the physician thought the elevation in the Claimant's pressures was minimal. Given Mr. Torres' history of leg injuries at Continental, Dr. Hughson was concerned that Mr. Torres may have sustained a deep vein thrombosis followed by pulmonary embolism which could possibly have resulted in chronic thromboembolic disease; however, Dr. Hughson noted the likelihood of such factors occurring was "extremely remote." The physician also stated a diagnosis of chronic thromboembolic disease could be excluded by performing a ventilation/perfusion scan. Dr. Hughson recommended that Continental or its workers' compensation carrier provide the test because Mr. Torres sustained a leg injury while working for Continental. Dr. Hughson also opined Mr. Torres' condition is permanent and stationary and that the Claimant can return to the job of a marine painter without restrictions. The physician stated that any disability due to mild esophagitis, esophageal motility disorder, and mild pulmonary hypertension should not be the responsibility of Pacific because those conditions have been present since 1993. Dr. Hughson reiterated that most of the Claimant's problems, in his opinion, were psychological or psychiatric in nature and cited the Claimant's "long history of anxiety and panic attacks prior to his employment at Pacific."

Dr. Lineback examined Mr. Torres again on March 7, 1996. (CX 10). The physician stated that since Mr. Torres left his painting job in July 1995 "his symptoms moderately improved" and his "easy fatigue [had] nearly resolved." Dr. Lineback detected no wheezes or rales upon physically examining the Claimant's lungs. The physician reviewed the results of an upper gastrointestinal study administered on August 24, 1995, which was within normal limits, and reviewed a January 30, 1996 pulmonary function study which yielded normal results. Dr. Lineback diagnosed Mr. Torres with shortness of breath secondary to intermittent broncho spasm. The physician found it "very instructive" that the Claimant had worked as a painter since the late 1970's and had been experiencing shortness of breath since the early 1990's. Dr. Lineback noted the Claimant's symptoms would improve while he was away from his job as a painter and would increase in severity when he returned to painting. The physician reiterated that Mr. Torres was continuously exposed to paint fumes with inadequate ventilation during his employment with Continental and Pacific. Dr. Lineback opined that "paint fumes are a well-known respiratory irritant that often cause occupational asthma and intermittent broncho spasm." The physician concluded intermittent broncho spasm was a "more suitable diagnosis" in the Claimant's case because the Claimant's pulmonary function tests showed no evidence of significant asthma. Dr. Lineback described intermittent broncho spasm as a "low grade form of asthma whereby the inhalation of respiratory irritants, such as paint fumes, may cause the narrowing of airways, thus causing symptoms of shortness of breath and resulting fatigue." Dr. Lineback thought the fact that Mr. Torres' symptoms would improve when he left his job and would increase in severity when he returned, was "virtually diagnostic of occupational causation." Consequently, Dr. Lineback concluded Mr. Torres' continuous exposure to paint fumes over a number of years significantly contributed to his

respiratory symptoms. The physician precluded Mr. Torres from further exposure to respiratory irritants, such as dust, fumes, chemicals, etc., in order to avoid further progression of the Claimant's symptoms. Dr. Lineback cautioned that failure to adhere to his restriction may result in "a gradual evolution of [Mr. Torres'] symptoms into occupational asthma." The physician stated it is "important that Mr. Torres not return to his job as a painter" because chronic exposure to paint fumes may increase the level of the Claimant's disability. According to Dr. Lineback, the Claimant's primary treatment consisted of avoiding further exposure to paint fumes. The physician opined the Claimant should be considered a "qualified injured worker and retrained for a different type of position that does not involve exposure to" paint fumes.

On July 5, 1996, Dr. Lineback reviewed Dr. William Hughson's January 25, 1996 medical report. (EX Q)(CX 10). Dr. Lineback questioned Dr. Hughson's reliance on the Claimant's normal spirometry results. The physician emphasized Mr. Torres' shortness of breath is related to intermittent narrowing of the airways. Because the narrowing of the airways was intermittent, the physician explained that Mr. Torres' pulmonary function studies may be within normal limits at virtually any given time. Dr. Lineback stated the normal spirometry results would not necessarily mean the Claimant has no industrial problem. Thus, Dr. Lineback reaffirmed his conclusion that the Claimant's respiratory symptoms were caused by intermittent broncho spasm secondary to the Claimant's exposure to paint fumes. The physician stated the conclusions he reached in his previous reports were not changed by Dr. Hughson's opinion.

On October 19, 1996, Mr. Torres was again treated in the Emergency Room of Scripps Memorial Hospital, this time by Dr. Melvin Ochs. (EX F). Mr. Torres complained of chest pains after having been struck forcibly in the chest during an altercation. Dr. Ochs noted a history of seizures, palpitations, and depression. According to Dr. Ochs, the Claimant stopped smoking in 1991 and is a social drinker. Dr. Kenneth Albertson interpreted an x-ray of the Claimant's chest as showing no abnormalities. An electrocardiogram administered during the examination was normal and showed no injury pattern. The physician diagnosed Mr. Torres with acute anterior chest pain and probable traumatic costochondral separation. Dr. Ochs instructed Mr. Torres not to work for the next seven days.

During November 1996, the Claimant was evaluated by Dr. David Vandenburg in the Emergency Room of Scripps Memorial Hospital for rapid heartbeat. (EX C). Dr. Vandenburg noted the Claimant experienced rapid heartbeat every three to four months, but stated the symptoms had been occurring much less frequently. Mr. Torres' primary complaint was a rapid heartbeat and a sense of tachycardia of moderate severity. An examination of the Claimant's lungs was normal and rapid tachycardia was noted. Dr. Vandenburg noted no evidence of acute psychiatric or emotional difficulty. An IV was ordered for Mr. Torres. According to Dr. Vandenberg, Mr. Torres "suddenly spontaneously reverted to normal sinus rhythm while the IV was being started." The physician stated the Claimant's sinus rhythm remained normal after the IV was started. An electrocardiogram

conducted prior to the conversion showed a narrow complex and rapid heart rate; however, an electrocardiogram administered after the conversion showed a normal sinus rhythm. Dr. Vandenberg diagnosed resolved episodic tachycardia and no specific treatment was proposed. The physician instructed the Claimant to see his private physician as necessary.

Dr. Hughson supplemented his January 1996 report on November 11, 1996 after reviewing the reports of Dr. Lineback dated March 7, 1996 and July 5, 1996, and a set of pulmonary function tests dated January 30, 1996. (CX 13). Dr. Hughson concluded there was "no objective basis for Dr. Lineback's diagnosis of intermittent broncho spasm of an industrial etiology." The physician opined Dr. Hughson improperly concluded that "because Mr. Torres develops symptoms at work which improve when he is away from work, this is sufficient to establish an industrial causation for intermittent broncho spasm." Dr. Hughson reiterated that Mr. Torres suffers from an underlying psychiatric or psychological condition, the symptoms of which have been present for "many years." Dr. Hughson opined the Claimant's work at Pacific did not aggravate, accelerate, or precipitate the Claimant's symptoms.

An August 11, 1999 medical record from U.S. Family Care Clinic indicates Mr. Torres went to San Antonio Hospital on August 10, 1999 because he was experiencing rapid heartbeat. (EX P). According to Dr. Alfred Davidas, the Claimant was diagnosed with paroxysmal supraventricular tachycardia. Dr. Davidas found "no organic explanation for [Mr. Torres'] symptoms. The physician noted the Claimant was "verbally abusive" and screamed at his wife when she tried to explain his condition. Dr. Davidas advised Mr. Torres to take his medications because the Claimant stated he had not been doing so. Dr. Davidas told Mr. Torres he needed to have "a better attitude when he came to the clinic." Dr. Davidas stated Mr. Torres responded "Have I beaten you up yet? How come you are getting upset?" at which point Dr. Davidas felt threatened and left the room. The manager of the clinic then referred the Claimant to Dr. Tooma.

Counsel for Continental deposed Mr. Torres on November 4, 1999. (EX K). Mr. Torres testified he has two children. *Id.* at 6. The Claimant stated he was employed by E. L. Yeager as a carpenter. *Id.* at 7. Mr. Torres had been working at E.L. Yeager for approximately three weeks prior to the deposition. *Id.* He was earning $19.42 per hour. *Id.* at 8. Mr. Torres stated his family physician is Dr. Tooma, a physician with whom he had been treating for almost three months as of the time of the hearing. *Id.* at 30. Prior to Dr. Tooma his treating physician was Dr. Tran. Dr. Petit treated the Claimant prior to Dr. Tran and Dr. de Carvalho was his treating physician prior to Dr. Petit. *Id.* At the time of the hearing, Mr. Torres was taking an asthma medication prescribed by Dr. Tran. (EX K, p. 32). The Claimant went to see Dr. Tran because he was having breathing problems. *Id.* at 35. The evidence of record contains no reports or treatment notes from Drs. Tran, Petit, or Tooma.

Mr. Torres testified he started wheezing approximately six months prior to the deposition and this prompted the visit to Dr. Tran. *Id.* at 36. The Claimant stated Dr. Tran diagnosed him with asthma

but did not tell him what caused the condition. *Id.* at 37. Mr. Torres denied chest pains but stated he does have headaches "every now and then." *Id.* Mr. Torres testified he always wore his respirator at Continental and does not recall having any problems with the respirator. *Id.* at 38. Mr. Torres attributes his problems to solvents, paints, and epoxies he used while at Continental. He believes his symptoms are consistent with those listed on the material data safety sheets for the chemicals he used during his work as a painter. (EX K, p. 40). Mr. Torres also attributes his condition to his work as a painter because he used to get sick when he worked in that environment. *Id.* at 58.

The Claimant sought psychological treatment for his breathing problems and rapid heartbeat. *Id.* at 42. He testified he saw one psychologist four times but the treatment did not help his symptoms. *Id.* Mr. Torres further testified he saw another psychologist in Tijuana for approximately one year. *Id.* According to Mr. Torres, the psychologist prescribed him medication for anxiety. *Id.* at 44. The evidence of record includes a report written by Dr. Juan Cerrud, two prescriptions from Dr. Martha Moncayo, and one prescription from Dr. Fernando Zamano; however, all of the documents are written in Spanish. (CX 6).

Dr. Kevin Glynn examined Mr. Torres on November 23, 1999. (EX V). The Claimant's primary complaints were rapid heartbeats, asthma, and chest pain. Dr. Glynn noted Mr. Torres smoked "intermittently from the age of twenty to about his late thirties." The Claimant smoked less than one pack of cigarettes per day and would stop smoking for several months at a time. The physician stated Mr. Torres had not smoked since 1993 and does not consume alcohol. Dr. Glynn noted the Claimant suffers from occasional dizziness, headaches, a chronic stuffy nose, and decreasing vision. The physician also reviewed Mr. Torres' employment history. He stated the Claimant was a spray painter from 1976 until he left his employment at Pacific, with the exclusion of three years the Claimant worked as an oil well driller from 1983-86. Dr. Glynn's examination included a physical examination and a pulmonary function study. The physician stated the pulmonary function study was normal. Dr. Glynn also reviewed extensive medical evidence of record.

Dr. Glynn reviewed the material safety data sheets on Proline 1220 which is a clean-up solvent. He noted the substance primarily contains organic hydrocarbons. The physician stated that in large quantities, organic hydrocarbons are central nervous system toxins. Dr. Glynn opined organic hydrocarbons are not pulmonary toxins, but can lead to pulmonary edema or can dry out the airways if massively inhaled. Dr. Glynn diagnosed recurrent tachycardias of a nonoccupational origin and found no sign of a permanent impairment. Dr. Glynn found no evidence to support a diagnosis of a pulmonary condition. The physician also diagnosed dyspepsia of a nonoccupational origin and stated the Claimant has a history of work place exposure to spray paint but no sign of occupational injury. The physician concluded it is "possible, in fact likely, that the Claimant's palpitations and tachycardia were what caused his feelings of shortness of breath." The physician concluded the symptoms were not "manifestations of asthma" because the Claimant's pulmonary function studies were normal, no wheezing was heard, and because he thought tachycardia was a good explanation for Mr. Torres'

symptoms. Dr. Glynn opined Mr. Torres is able to work as a carpenter and engage in full activity. Because Dr. Glynn found no pulmonary impairment, he found no disability. The physician opined Mr. Torres is able to work as either a spray painter or a carpenter without restrictions or modifications. He opined the Claimant's prognosis is "good" and that the Claimant needs no further treatment for any pulmonary condition.

Dr. Glynn testified during the December 16, 1999 formal hearing. (Tr. 58). He stated he first evaluated Mr. Torres on November 17, 1999. Dr. Glynn's evaluation included a physical examination, a pulmonary function study, the Claimant's history of injury, and a review of medical records supplied by the Claimant. According to Dr. Glynn, the pulmonary function studies revealed no significant impairment in pulmonary function. *Id.* at 64. The physician concluded Mr. Torres does not suffer from industrial asthma or any other occupationally induced pulmonary condition.

Dr. Glynn explained several factors must be present in order to support a diagnosis of industrial asthma. The physician stated there must be some temporal connection between the Claimant's symptoms and his industrial exposure. He opined individuals with occupational asthma generally tend to get better once the occupational exposure ceases. Dr. Glynn also stated the symptoms from which the Claimant suffers should also be consistent with those of occupational asthma. He stated people who suffer from occupational asthma suffer from shortness of breath and wheezing but not palpitations and the type of sensation Mr. Torres was having in his chest. Dr. Glynn also thought there should have been some physical examination findings consistent with asthma documented by the Claimant's treating and examining physicians during the five years prior. The physician acknowledged asthma "comes and goes," but stated that with

all of the visits Mr. Torres made to physicians, someone should have heard wheezes or noted other signs of respiratory obstruction at some point.

Dr. Glynn concluded tachycardia offers a "full, sufficient, and adequate explanation" of Mr. Torres' symptoms. The physician explained that individuals who have supraventricular tachycardias get palpitations or the sensation that there is something strange or hot inside their chest. Dr. Glynn also was unpersuaded by the fact that Mr. Torres had been prescribed an asthma inhaler and thought there was "some" improvement with the inhaler. The physician stated Mr. Torres' opinion about the effects of the inhaler "did not hold water to [him] the way [he] would expect somebody with asthma to respond." Based on all of these findings, Dr. Glynn concluded a diagnosis of asthma, especially industrial asthma, was "very weak."

Dr. Glynn did not attribute the diagnosed tachycardia to the Claimant's occupation as a spray painter for two reasons. First, Mr. Torres experienced his first tachycardia on the way to work, not while he was at work. Second, the physician stated the only way an organic hydrocarbon solvent exposure could cause a tachycardia is if an individual were to inhale a large amount of the substance.

The physician stated in the event of such an exposure, the symptoms should occur right away rather than be delayed. Dr. Glynn also noted if the patient did not die from the exposure, the tachycardia would go away "pretty fast." Dr. Glynn stated Mr. Torres' pulmonary function is 120% of the average pulmonary function for individuals his age. (Tr. 69). If the Claimant had industrial asthma, Dr. Glynn stated he would have "expect[ed]" the flow rates on the Claimant's pulmonary function studies to be a little low and perhaps after a bronchodilator was administered the flow rates would have improved 20-25% or more. Mr. Torres' pulmonary function studies yielded no such findings. Dr. Glynn disagreed with Dr. Lineback's diagnosis of intermittent broncho spasm because he thought the physician should have had a factual basis for making such a diagnosis. *Id.* at 74. He stated if a physician diagnoses intermittent broncho spasm, there should be "diminution in the flow rates on pulmonary function, and physical findings of wheezing, and the story should sound like asthma." The physician opined Mr. Torres' "story sounds like tachycardia." Dr. Glynn also noted Dr. Glassman's finding of no cardiovascular disease was not inconsistent with a diagnosis of tachycardia. *Id.* at 76. He explained that individuals who have supraventricular tachycardias "most of the time do not have any demonstrable organic heart disease."

Dr. Glynn also addressed Dr. Han's rule-out diagnosis of toxic fume syndrome. *Id.* at 79. The physician stated an individual who has toxic fume syndrome would suffer from coughing, wheezing, and shortness of breath. He stated the duration of the symptoms varies depending on how caustic and how intense the exposure was. Dr. Glynn stated the symptoms improve in time absent further exposure to toxic substances, but acknowledged individuals with toxic fume syndrome show abnormalities on pulmonary function studies several years after the exposure. *Id.* at 80. Nevertheless, Dr. Glynn concluded the record did not contain any evidence that Mr. Torres suffered from toxic fume syndrome. The physician stated a toxic reaction within high concentrations over short periods of time might cause an individual to have a rapid heartbeat. Such an individual would also experience shortness of breath if the individual had asthma, wheezing, and acute inflammation and spasm of the airways. However, the physician stated Mr. Torres showed no such findings. Dr. Glynn concluded Mr. Torres does not suffer from an occupational pulmonary condition related to his exposure to paint fumes at Continental. (Tr. 81).

On cross-examination, Dr. Glynn stated tachycardia is a generic term for "rapid heart beat." When asked if an individual can suffer from intermittent broncho spasm without an underlying lung disease, Dr. Glynn stated intermittent broncho spasm is a manifestation of asthma and asthma is a form of lung disease. *Id.* at 84. Dr. Glynn acknowledged there have been "cases of asthma associated with the resins and hydrocarbons in spray paints." The physician stated he would consider Mr. Torres' complaints of shortness of breath to be temporal in nature to his employment at Continental provided the Claimant had experienced shortness of breath two to three times per week during his employment at Continental, had not experienced shortness of breath prior to his employment at Continental, and had experienced shortness of breath only on a couple of occasions in the past year. *Id.* at 89. Dr. Glynn also stated he does not believe Mr. Torres suffers from asthma induced by reflux esophagitis. *Id.* at 96. The physician opined esophagitis can also trigger tachycardias and cause chest pains. *Id.* at 97. Dr.

Glynn stated he found no evidence that the esophagitis was related to Mr. Torres' work as a spray painter. *Id.* at 98. The physician stated the records he reviewed contain minimal mention of shortness of breath and rapid heartbeat during the time the Claimant worked at Continental. *Id.* at 100-101. Dr. Glynn opined Mr. Torres can return to his previous job as a spray painter if he chooses to do so. *Id.* at 103. The physician noted that the Claimant, like any other worker, is entitled to good industrial hygiene. *Id.* at 104.

CONCLUSIONS OF LAW

Injury Arising Out of and in the Course of Employment

A person seeking benefits under the LHWCA has the burden of persuasion by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 114 S. Ct. 2241, 28 BRBS 43 (1994). In determining whether Mr. Torres has sustained an injury compensable under the Act, I must consider the relationship between Sections 2(2) and 20(a) of the Act. Section 2(2) of the LHWCA defines "injury" as:

> accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally and unavoidably results from such accidental injury, and includes injury caused by the willful act of a third person directed against an employee because of his employment.

33 U.S.C. § 902(2).

Section 20(a) of the Act, 33 U.S.C. § 920(a), creates a presumption that a claimant's disabling condition is causally related to the claimant's employment. In order to invoke the Section 20(a) presumption, a claimant must first establish a prima facie claim for compensation under the Act. *See Kelaita v. Triple A Mach. Shop*, 13 BRBS 326, 330-31 (1981), *aff'd sub nom. Kelaita v. Director, OWCP*, 799 F. 2d 1308 (9th Cir. 1986); *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128 (1984). The claimant must show he or she sustained physical harm or pain and that an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. *See Merrill v. Todd Pacific Shipyards Corp.*, 25 BRBS 140 (1991); *Stevens v. Tacoma Boat Bldg. Co.*, 23 BRBS 191 (1990). If a claimant establishes a prima facie case, the claimant's injury is presumed to have arisen out of the claimant's employment under Section 20(a). I note this statutory presumption neither dispenses with the requirement that a claim of injury be made in the first place nor is it a substitute for the evidence required to establish a prima facie case. *See generally, U.S. Indus./Fed. Sheet Metal v. Director, OWCP*, 455 U.S. 608 (1982), *rev'g Riley v. U.S. Indus./Fed. Sheet Metal*, 627 F. 2d 455 (D.C. Cir. 1980). Once the presumption is invoked, the burden of production then shifts to the employer to establish the claimant's injury was not caused or

aggravated by the claimant's employment. *See Brown v. Pacific Dry Dock*, 22 BRBS 284 (1989); *Rajotte v. General Dynamics Corp.*, 18 BRBS 85 (1986). The Section 20(a) presumption can only be rebutted by substantial countervailing evidence that the claimant's injury was not caused by his employment. *See Sinclair v. United Food & Commercial Workers*, 23 BRBS 148, 154 (1989). If the employer successfully rebuts the presumption, it no longer controls, and I must look at all of the evidence of record to determine whether the claimant's injury arose out of and in the course of his employment with the employer. *See, Del Vecchio v. Bowers*, 296 U.S. 280 (1935); *Volpe v. Northeast Marine Terminals*, 671 F. 2d 697 (2d Cir. 1982).

Prima Facie Case

To establish a prima facie claim for compensation, Mr. Torres need not affirmatively establish a nexus between his employment and the harm he alleges he has suffered. Rather, Mr. Torres must establish only that he sustained physical harm or pain and that an accident occurred in the course of employment, or working conditions existed, that could have caused the harm or pain. *See Clophus v. Amoco Prod. Co.*, 21 BRBS 261, 265 (1988). A claimant's credible subjective complaints of symptoms and pain can constitute sufficient proof of the requisite physical harm and the invocation of the 20(a) presumption. *See, Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub nom., Sylvester v. Director, OWCP*, 681 F. 2d 359 (5th Cir. 1982). However, the claimant's theory as to how the alleged injury occurred must go beyond "mere fancy." *See Champion v. S & M. Traylor Bros.*, 690 F. 2d 285, 295 (D.C. Cir. 1982).

Mr. Torres alleges he suffers from shortness of breath, rapid heartbeat, and chest pains which are related to his employment as a painter with Continental. (EX I). The Claimant contends the injury was continuous in nature from July 14, 1994 through July 14, 1995. (EX I)(CX 1). Pulmonary problems can constitute an injury under the Act if related to the Claim-ant's work environment. Mr. Torres believes his condition is related to his employment at Continental because some other individuals he worked with at Continental have developed asthma and because he has no family history of asthma. (Tr. 57).

Mr. Torres submitted several medical opinions from Dr. James Lineback in support of his claim for compensation. Dr. Lineback is board-certified in internal medicine and pulmonary medicine. On August 23, 1995, Dr. Lineback became Mr. Torres' treating physician. (CX 8)(EX M). Dr. Lineback issued his First Report of Occupational Injury on the same day. *Id.* At that time, the physician stated the Claimant was suffering from shortness of breath and fatigue. Dr. Lineback described the occurrence of the Claimant's injury as "toxic fume inhalation →fatigue & sob." *Id.* Dr. Lineback concluded asthma needed to be ruled out as a possible diagnosis. No physical examination findings were noted and no treatment was rendered. The physician indicated an x-ray and lab results were "pending."

Dr. Lineback examined Mr. Torres again on September 3, 1995 and diagnosed palpitations, persistent nausea, shortness of breath, easy fatigue, and abdominal pain. (CX 10). During the examination, Dr. Lineback reviewed a material safety data sheet on Proline 1220. According to the physician, the data sheet stated that if inhaled, Proline 1220 can cause headaches, dizziness, nausea, and vomiting. Dr. Lineback also stated the data sheet indicated "chronic exposure could result in elevated carboxyhemoglobin levels in patients exposed to methylene chloride and can cause a substance stress on the cardiovascular system." Dr. Lineback never mentioned whether the Claimant had in fact been exposed to Proline 1220.

Dr. Lineback treated the Claimant on five more occasions from September 27, 1995 through January 17, 1996. (CX 8). Dr. Lineback's interim reports on the Claimant's visits contain repeated diagnoses of shortness of breath, abdominal pain, and palpitations. *Id.* In a March 7, 1996 examination report and a July 5, 1996 supplemental report, Dr. Lineback diagnosed Mr. Torres with shortness of breath secondary to intermittent broncho spasm secondary to paint fume exposure. (CX 10). The physician stated paint fumes "are a well-known respiratory irritant that can often cause asthma and broncho spasm." The physician characterized intermittent broncho spasm as " a low grade form of asthma caused by the inhalation of respiratory irritants, such as paint fumes, cause a narrowing of the airways which results in shortness of breath and fatigue." Mr. Torres testified he was exposed to paint fumes while working as a painter for both Continental and Pacific. (Tr. 58). I find Dr. Lineback's opinions and Mr. Torres' testimony sufficient to establish that Mr. Torres suffered a harm and that the conditions in which Mr. Torres worked as a painter for Continental could have caused the Claimant's injury.

Rebuttal Evidence

Because I have found the evidence sufficient to invoke Section 20(a) of the Act, I presume Mr. Torres' injury was related to his employment at Continental. Continental may rebut this presumption by presenting "substantial evidence" which either proves the absence of, or severs the connection between, the Claimant's harm and the conditions in which he worked at Continental. *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128, 129 (1984). "Substantial evidence" is the kind of evidence a reasonable mind might accept as adequate to support a conclusion. *See, Noble Drilling Co. v. Drake*, 795 F. 2d 478 (5th Cir. 1986); *Travelers Ins. Co. v. Belair*, 412 F. 2d 297 (1st Cir. 1969). In evaluating the evidence, I am entitled to weigh the medical evidence and draw my own inferences from it and I am not bound to accept the opinion or theory of any particular medical examiner. *See Todd Shipyards v. Donovan*, 300 F. 2d 741 (5th Cir. 1962).

Continental has submitted numerous pieces of evidence in support of its argument that Mr. Torres did not sustain an injury arising out of and in the course of his employment with the company. Continental submitted records from Dr. Carlos de Carvalho, a physician who treated Mr. Torres from May 18, 1995 through June 23, 1997. (EX F). Dr. de Carvalho's records contain diagnoses of acute

gastroenteritis, paroxysmal atrial tachycardia, and a panic disorder. The physician never identified a cause for any of the diagnosed conditions. Therefore, I find Dr. de Carvalho's records cannot be used to rebut the Section 20(a) presumption. On June 1, 1995 and November 11, 1996, Dr. de Carvalho noted Mr. Torres "may need to see a psych. soon," but offered no explanation as to why he arrived at such a conclusion.

Both the Claimant and the Employer submitted an examination report from Dr. William Hughson dated January 25, 1996. (CX 13)(EX A). Dr. Hughson is board-certified in internal medicine, pulmonary medicine, and occupational medicine. Dr. Hughsons' evaluation of Mr. Torres included Mr. Torres' medical, occupational, and smoking histories, a physical examination and a review of records from Dr. Lineback, Dr. de Carvalho, Dr. Wiener, Dr. Mullvain, Dr. Farris, Continental, the United States Department of Labor, Paradise Valley Hospital, and Scripps Memorial Hospital. Through the medical records review, Dr. Hughson learned Mr. Torres underwent a May 5, 1994 echocardiogram which Dr. Jeffrey Mullvain concluded indicated the presence of "very mild pulmonary hypertension." The physician also noted Dr. Wiener's records established that Mr. Torres suffers from an esophageal disorder and mild esophagitis. The physician stated the Claimant's mild esophagitis and esophageal motility disorder were not related to his employment at Pacific. Dr. Hughson noted all of Mr. Torres' problems were present during his employment at Continental; however, the physician offered no opinion as to whether the esophageal disorder and esophagitis were related to the Claimant's employment with Continental. Dr. Hughson also concluded Mr. Torres "may have primary pulmonary hypertension or possibly chronic thromboembolic disease." The physician opined that Mr. Torres had a history of leg injuries while working at Continental which could have caused a deep vein thrombosis followed by a pulmonary embolism which could possibly have resulted in chronic thromboembolic disease; however, Dr. Hughson stated the likelihood of this sequence of events occurring was "extremely remote." Dr. Hughson thought Dr. Mullvain's diagnosis of pulmonary hypertension was questionable because the Claimant's pressures were only minimally elevated, "possibly within the limits of the measurements." Nevertheless, the physician did not attribute the pulmonary hypertension to Mr. Torres' work as a painter for Continental. The physician noted the Claimant had a long history of anxiety and panic attacks associated with his physical complaints. Dr. Hughson stated the anxiety and panic attacks "could" cause Mr. Torres to have a rapid heart beat, palpitations, and abdominal discomfort. The physician expressed concern that Mr. Torres may suffer from claustrophobia aggravated by the use of a respirator or work in confined spaces. Dr. Hughson thought most of Mr. Torres' problems were psychological or psychiatric in nature. Dr. Hughson stated "the most important form of medical treatment...would be evaluation by a psychiatrist or psychologist." The physician never stated whether the perceived psychiatric or psychological problems were related to Mr. Torres' employment with Continental. I find Dr. Hughsons' opinion equivocal because the physician offered no clear explanation for the Claimant's palpitations, rapid heart beat, and abdominal discomfort. He also stated anxiety and panic attacks could cause these symptoms but reached no definitive conclusion as to whether those conditions actually caused the symptoms

from which Mr. Torres suffers. Consequently, I find Dr. Hughson's January 25, 1996 opinion insufficient to sever the relationship between the Claimant's injury and his work at Continental.[2]

The parties have also submitted a supplemental report from Dr. Hughson dated November 11, 1996. (CX 13)(EX M). Dr. Hughson rendered the report after reviewing Dr. Lineback's March 7, 1996 examination report in which Dr. Lineback diagnosed shortness of breath secondary to intermittent broncho spasm. The physician also reviewed a January 30, 1996 pulmonary function test that Dr. Lineback considered before rendering the diagnosis of intermittent broncho spasm. Dr. Hughson found no objective basis for Dr. Lineback's diagnosis. He reiterated that Mr. Torres suffers from "an underlying psychological or psychiatric condition, with panic attacks" and stated the Claimant's employment at Pacific did not cause, aggravate, accelerate or precipitate the Claimant's symptoms. Dr. Hughson offered no opinion as to the cause of Mr. Torres' alleged psychological or psychiatric problems. Thus, his opinion does not establish a lack of causation.

Continental has also submitted a number of records which document Mr. Torres' medical history.[3] The records indicate the Claimant has been treated by physicians on a number of occasions for various conditions, including the symptoms which the Claimant alleges in the instant proceeding. None of the records contain an opinion as to the cause of the conditions diagnosed in the records. I note the records are important to the extent they document the concerns of several physicians who think Mr. Torres may suffer from a psychological or psychiatric condition; however, none of those physicians offered an opinion as to the etiology of the Claimant's alleged psychological or psychiatric problems. The records also indicate Mr. Torres did not complain of shortness of breath or rapid heartbeat until August 1995 when Dr. Lineback began treating him. Nevertheless, I find the fact that

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[2] I note that Dr. Hughson's theory of possible chronic thromboembolic disease is speculative. The physician acknowledged the likelihood of the disease resulting from leg injuries the Claimant sustained while working for Continental was "extremely remote." Furthermore, the Claimant is not seeking compensation for a leg injury nor does the record indicate that such an injury occurred.

[3] The records are as follows: a February 14, 1993 emergency room record from Community Hospital (containing diagnosis of esophageal spasm and gastritis)(EX E); two letters written by Dr. Wiener during March 1993 (diagnosis of mild esophagitis and esophageal motility disorder)(EX E, R); an April 20, 1993 chest x-ray (interpreted by Dr. John Wells as normal)(EX H); an October 5, 1993 neurological examination by Dr. Stephen Stecker (rule out diagnoses of polymyalgia, chest or esophageal disease, and arthritic changes in the right shoulder joint)(EX R); an October 6, 1994 respirator fit test which Mr. Torres passed (EX H); an annual painter's examination dated October 27, 1994 (concluding Claimant able to perform all four job classes)(EX H); emergency room records from Scripps Memorial Hospital dated May 1995 (documenting treatment of head injury and abdominal pain)(EX C); absentee slips from Continental (documenting Mr. Torres' absences from work)(EX H); a June 27, 1995 examination and statement of medical restrictions and limitations (EX D); a July 19, 1995 chest x-ray (interpreted by Dr. C. D. Lee as normal)(EX D); an upper gastrointestinal series administered by Dr. Hano Siegel on August 24, 1995(EX Q); an October 19, 1996 emergency room record (diagnosing chest pain and probable traumatic costochondral separation) (EX F); a November 1996 emergency room record from Scripps Memorial Hospital (diagnosing resolved episodic tachycardia)(EX C); and an August 11, 1999 record from U.S. Family Care Clinic (diagnosing supraventricular tachycardia)(EX P).

the Claimant's treatment records do not document shortness of breath and rapid heartbeat during the Claimant's employment with Continental is insufficient to rebut the presumption of industrial causation.

The Employer and the Claimant have also submitted Dr. Alex Han's First Report of Occupational Injury dated July 19, 1995. (EX D)(CX 5). After Mr. Torres underwent physical examination, a chest x-ray, an electrocardiogram and a pulmonary function study, Dr. Han concluded he needed to rule out the possibility of toxic fume syndrome and stated the results of the chest x-ray were pending. Because Dr. Han offered no definitive diagnosis of Mr. Torres' symptoms, his opinion is of little value to the Employer's rebuttal.

To rebut the presumption of industrial causation, Continental primarily relies on the report and hearing testimony of Dr. Kevin Glynn, a physician who is board-certified in internal medicine and pulmonary medicine. (EX S, V). Dr. Glynn examined Mr. Torres on November 23, 1999. (EX V). After examining the Claimant, noting his occupational, smok-bing, and medical histories, and reviewing material safety data sheets of Proline 1220 and the Claimant's medical records, Dr. Glynn diagnosed the Claimant with recurrent tachycardias of a nonoccupational origin, dyspepsia of a nonoccupational origin, and a history of workplace exposure to spray paint. Dr. Glynn stated Mr. Torres' symptoms of chest pain, rapid heartbeat and shortness of breath were not manifestations of asthma because Mr. Torres' pulmonary function studies were normal, no wheezes were heard by any physician during physical examination, and because tachycardia provided a good explanation of the Claimant's symptoms.

During the December 1999 hearing, Dr. Glynn further explained why he concluded Mr. Torres suffers from tachycardia of a nonoccupational origin rather than intermittent broncho spasm related to paint fume exposure. Dr. Glynn stated there are three reasons why he disagrees with Dr. Lineback's diagnosis of industrial asthma. First, Dr. Glynn stated there must be some temporal connection between the Claimant's symptoms and his industrial exposure before a physician can diagnose asthma. On cross-examination, Dr. Glynn conceded that Mr. Torres' symptoms were temporal to his employment at Continental. Nevertheless, the physician stated an individual must also have symptoms consistent with asthma before a diagnosis of the disease can be made. He explained a person with asthma suffers from shortness of breath and wheezing, but not palpitations. Dr. Glynn noted Mr. Torres' medical records contain only minimal mention of shortness of breath and rapid heart beat during the time Mr. Torres worked for Continental. Third, Dr. Glynn stated that even though asthma comes and goes, there should have been some physical findings consistent with asthma noted by at least one of the many physicians who have treated the Claimant. The physician stated if Mr. Torres suffered from asthma, he would have expected at least one physician of record to note wheezing on physical examination or some other signs of respiratory obstruction. The physician also stated he would have expected the flow rates on the Claimant's pulmonary function tests to be a little low and to have shown at least a 20-25% improvement after administration of a bronchodilator. In contrast, Dr. Glynn noted

Mr. Torres' pulmonary function was normal, specifically 120% of the average pulmonary function for someone of the Claimant's age and height.

Dr. Glynn also explained why he does not believe Mr. Torres suffers from toxic fume syndrome, a condition from which Dr. Han thought the Claimant may suffer. Dr. Glynn stated an individual who suffers from toxic fume syndrome experiences coughing, wheezing, and shortness of breath. According to the physician, the duration of these symptoms would vary depending on how intense and how caustic an individual's exposure is. The physician also noted someone who is exposed to a toxic reaction within high concentration over a short period of time may suffer from rapid heartbeat, if the individual had asthma, wheezing, and acute inflammation and spasm of the airways. However, Dr. Glynn stated Mr. Torres showed no such findings.

Dr. Glynn did not attribute the diagnosed tachycardia to Mr. Torres' employment at Continental. The physician emphasized the Claimant's first episode of shortness of breath occurred while he was on his way to work rather than during work. Dr. Glynn opined the only way an organic hydrocarbon solvent (such as Proline 1220) could cause tachycardia is if Mr. Torres had inhaled a large amount of fumes from the solvent. Even then, the physician stated the Claimant's symptoms would have occurred right away and would not have been delayed. Dr. Glynn also acknowledged esophagitis can trigger tachycardias and cause chest pain; however, the physician found no evidence the esophagitis from which Mr. Torres suffers is related to his employment as a painter. Because Dr. Glynn unequivocally testified Mr. Torres' symptoms are not related to his employment with Continental, I find his opinion constitutes substantial evidence to rebut the presumption of industrial causation. *See Kier*, 16 BRBS at 129-30. Because the Employer has rebutted the section 20(a) presumption, I must now evaluate all of the evidence of record to determine whether Mr. Torres' symptoms are related to his employment with Continental. *See Del Vecchio v. Bowers*, 296 U.S. 280 (1935); *Volpe v. Northeast Marine Terminals*, 671 F. 2d 697 (2d Cir. 1981); *Holmes v. Universal Maritime Serv. Corp.*, 29 BRBS 18 (1995).

Industrial Causation

Prior to the United States Supreme Court's decision in *Director, OWCP v. Greenwich Collieries, (Maher Terminals)*, 512 U.S. 267, (1994), the "true doubt" rule applied to the adjudication of benefits claims under the LHWCA. The rule required a factfinder to resolve doubtful questions of fact in favor of the injured employee. *See Parsons v. Director, OWCP*, 619 F. 2d 38, 41 (9th Cir. 1980). Thus, the true doubt rule placed a less stringent burden of proof on the claimant than the preponderance of the evidence standard applied in civil suits. *See Noble Drilling Co. v. Drake*, 795 F. 2d 481 (5th Cir. 1986). If the evidence were in equipoise on a particular issue, the true doubt rule enabled the claimant to prevail on that issue. In *Greenwich Collieries*, the Supreme Court held that an injured worker seeking compensation under the LHWCA must prove the elements of his claim

by a preponderance of the evidence.[4] As Continental has rebutted the presumption of industrial causation, Mr. Torres now bears the burden of proving causation by a preponderance of the evidence. If in weighing all of the evidence of record, I find it to be evenly balanced as to the issue of causation, Mr. Torres will not prevail.

I note that in considering all of the evidence, an administrative law judge may accord greater weight to the opinions of treating physicians than the opinions of examining physicians or consulting physicians. *See Amos v. Director, OWCP*, 153 F. 3d 1051, 1054 (9th Cir. 1998) (citing *Magallanes v. Bowen*, 881 F. 2d 747, 751 (9th Cir. 1989)). The evidence of record contains the examination reports and treatment records of two of the Claimant's treating physicians, Dr. Lineback and Dr. de Carvalho. Dr. Lineback is board-certified in internal medicine and pulmonary medicine. Dr. de Carvalho's qualifications are not in the record. Dr. Lineback is the only physician of record who has diagnosed the Claimant with an intermittent broncho spasm and is the only physician of record who has attributed the Claimant's condition to his work as a painter.

When Dr. Lineback first treated Mr. Torres on August 23, 1995, he described Mr. Torres' injury as "toxic fume inhalation → sob and fatigue" and stated asthma needed to be ruled out as a possible diagnosis. (CX 8). Dr. Lineback did not note any physical findings and stated the results of a chest x-ray were "pending." The physician did not review any of the Claimant's medical records. Dr. Lineback also did not determine the date on which Mr. Torres could return to work and simply stated "?pending testing." From September 3, 1995 through March 7, 1996, Dr. Lineback continued to treat the Claimant and diagnosed such symptoms as shortness of breath, palpitations, easy fatigue, nausea and abdominal pain; however, Dr. Lineback did not relate any of these symptoms to the Claimant's employment at Continental until March 7, 1996. (CX 10).

After examining Mr. Torres on March 7, 1996 and finding no rales or wheezes in his lungs, and after reviewing the normal results of an August 24, 1995 upper gastrointestinal series and a normal January 30, 1996 pulmonary function study, Dr. Lineback concluded Mr. Torres suffers from shortness of breath secondary to intermittent broncho spasm which the physician considered to be "a low grade form of asthma." The physician stated paint fumes are a well-known respiratory irritant that can cause asthma and broncho spasm; however, Dr. Lineback stated intermittent broncho spasm was a more appropriate diagnosis because the Claimant's pulmonary function study showed no significant sign of asthma. Dr. Lineback attributed the Claimant's condition to his exposure to paint fumes because Dr. Lineback thought the fact that

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[4] I note the Benefits Review Board held in *Holmes v. Universal Maritime Servs. Corp.*, 29 BRBS 18, 21 (1995), that "the Supreme Court's decision in *Greenwich Collieries* did not discuss or affect the law regarding the invocation and rebuttal of the Section 20(a) presumption."

the Claimant's symptoms improved when he was not working as a painter and worsened when he resumed working as a painter, was "virtually diagnostic of industrial causation."

Although Dr. Lineback was one of Mr. Torres' treating physicians, there are several reasons why I find his opinion insufficient to satisfy the Claimant's burden of proof. Dr. Lineback's diagnosis of intermittent broncho spasm related to the Claimant's exposure to paint fumes is neither documented nor reasoned. Other than the fact that Dr. Lineback thought the normal January 30, 1996 pulmonary function study was not inconsistent with a finding of intermittent broncho spasm, the physician offered no objective medical evidence or physical examination findings to support his diagnosis of intermittent broncho spasm. Dr. Glynn testified that if Mr. Torres' suffers from asthma he should have experienced wheezing in addition to shortness of breath, at least one of the many physicians of record who have examined Mr. Torres should have noted wheezing or some other respiratory obstruction on physical examination, and that he would have expected Mr. Torres' pulmonary function tests to be a little low and to have shown 20-25% improvement after administration of a bronchodilator. Because Dr. Lineback never discussed any of the symptoms from which an individual with intermittent broncho spasm suffers and never related those symptoms to the Claimant's condition, I find Dr. Glynn's opinion as to the medical findings which are manifestations of asthma are uncontradicted. Consequently, because neither Dr. Lineback nor any other physician of record noted any of the signs of asthma identified by Dr. Glynn, I find the evidence of record does not support Dr. Lineback's diagnosis of intermittent broncho spasm. Moreover, I note Dr. Lineback's finding of industrial causation is poorly reasoned and documented. In support of his finding of industrial causation, Dr. Lineback relied solely on the fact that Mr. Torres' symptoms improved when he left his job as a painter and increased in severity when he returned to such employment. The physician never explained why such a sequence of events indicates Mr. Torres' symptoms are related to his employment rather than some other nonoccupational condition.

I also find Dr. Lineback's opinion insufficient to establish an injury arising out of and in the course of Mr. Torres' employment because Dr. Lineback never reviewed and discussed the medical evidence of record. The medical evidence of record contains the opinions of other physicians who have suggested Mr. Torres may suffer from tachycardia, claustrophobia aggravated by respirator use, or some other type of psychological or psychiatric problem. I note Dr. Lineback reviewed the January 1, 1996 examination report of Dr. Hughson, but offered no response to Dr. Hughson's opinion that he "strongly suspected" Mr. Torres' may be suffering from claustrophobia or some type of psychiatric or psychological problem.

Dr. Lineback also did not review the treatment records of Dr. de Carvalho, a physician who treated Mr. Torres for approximately two years. Dr. de Carvalho treated Mr. Torres from May 18, 1995 through June 23, 1997, unlike Dr. Lineback who only treated Mr. Torres for less than one year. Dr. de Carvalho's treatment records contain repeated diagnoses of paroxysmal atrial tachycardia, panic disorder, and acute gastroenteritis. Dr. de Carvalho offered no opinion as to the cause of the

conditions diagnosed in his treatment records. Nevertheless, the physician's records do not support a diagnosis of intermittent broncho spasm. Dr. de Carvalho's records lend support to Dr. Glynn's diagnosis of tachycardia and to the opinions of the physicians of record who have indicated Mr. Torres may have some psychological or psychiatric problems. The records indicate Dr. de Carvalho was concerned that Mr. Torres may have some psychological issues. Dr. de Carvalho first commented the Claimant may need to see a psychologist during a June 1, 1995 examination. On November 11, 1996, the physician again stated Mr. Torres may need to see a psychologist soon.

Dr. Lineback also failed to consider the medical treatment records regarding Mr. Torres which existed at the time he rendered his opinions. He did not consider Dr. Wiener's 1993 reports, finding no organic cause for the Claimant's chest pains and concluding Mr. Torres' unwillingness to obtain psychological help was the "crux" of his problems. (EX R).

In contrast, Dr. Glynn's opinion is entitled more evidentiary weight than Dr. Lineback's opinion because Dr. Glynn based his conclusions on a thorough physical examination and an extensive medical records review. As discussed above in reference to rebuttal of the 20(a) presumption, Dr. Glynn offered a thorough and unequivocal explanation of why he concluded Mr. Torres suffers from tachycardia of a nonindustrial origin rather than intermittent broncho spasm of an industrial origin. Dr. Glynn also defended his opinions on cross-examination during the formal hearing. Furthermore, I accord greater weight to Dr. Glynn's diagnosis of tachycardia because his diagnosis is supported by the Dr. de Carvalho's records, a physician who treated Mr. Torres for two years, and by Dr. Vandenburg, who treated the Claimant on an emergency basis during November 1996. (EX C).

I also note the opinions of Drs. Han, Glassman, and Hughson fail to support Mr. Torres' allegation that he suffered an injury related to his work as a painter. Dr. Han prepared a First Report of Occupational Injury on July 19, 1995 in connection with Mr. Torres' claim against Pacific. (EX D). Dr. Han stated the Claimant's chest x-ray results were pending and that he needed to rule out toxic fume syndrome as a possible diagnosis. Because Dr. Han offered no definite diagnosis of Mr. Torres' condition, I find his opinion is equivocal and is entitled little evidentiary weight.

Dr. Glassman examined Mr. Torres on November 30, 1995. (CX 12). The physician diagnosed Mr. Torres with abdominal pain of an unknown etiology, chest pain of an unclear etiology, mild obesity, possible anxiety neurosis, and panic attacks. Dr. Glassman found no evidence of organic disease or coronary artery disease, but acknowledged that such findings do not mean there is not an underlying cause which simply has not yet been discovered. Because Dr. Glassman did not offer an opinion as to the cause of the diagnosed conditions, his opinion cannot support a finding of industrial causation.

Mr. Torres was examined by Dr. Hughson on January 25, 1996. (CX 13). Dr. Hughson is board-certified in internal medicine, pulmonary medicine, and occupational medicine. Dr. Hughson

examined the Claimant, took a detailed employment history from the Claimant, and reviewed extensive medical evidence of record before rendering his opinion. Dr. Hughson concluded Drs. Wiener and Mullvain established that Mr. Torres suffers from mild esophagitis and an esophageal motility disorder. Dr. Hughson noted the Claimant underwent a cardiac catheterization on July 11, 1994 which was normal except that the presence of mild pulmonary hypertension was noted. Dr. Hughson questioned the finding of mild pulmonary hypertension because the physician thought the Claimant's pressures were only slightly elevated. The physician also noted Mr. Torres may suffer from chronic thromboembolic disease resulting from a pulmonary embolism which could have possibly been caused by a deep vein thrombosis during one of Mr. Torres' leg injuries at Continental; however, the physician thought the likelihood of such factors actually occurring was "extremely remote. Dr. Hughson was concerned that Mr. Torres may suffer from claustrophobia aggravated by the use of a respirator or his work in confined spaces or some other psychiatric problem. The physician noted approximately 10% of individuals who are evaluated for respirator use cannot wear the device because of claustrophobia. Dr. Hughson noted the Claimant has a long history of anxiety and panic attacks associated with his physical complaints. Unlike Dr. Lineback, Dr. Hughson found no basis for diagnosing a pulmonary condition and noted multiple pulmonary function studies were normal. Dr. Hughson did not attribute any of the diagnosed conditions to the Claimant's employment with Pacific and offered no opinion as to whether the mild esophagitis, esophageal motility disorder, or alleged psychiatric problems were related to the Claimant's employment with Continental. Thus, Dr. Hughson's opinion does not support a finding of causation.

I note that Dr. Hughson attacked Dr. Lineback's diagnosis of intermittent broncho spasm of an industrial etiology in a report dated November 11, 1996. (CX 13). After reviewing Dr. Lineback's March 7 and July 5, 1996 reports, and the January 30, 1996 pulmonary function study on which Dr. Lineback relied in diagnosing intermittent broncho spasm, Dr. Hughson found no objective basis for Dr. Lineback's diagnosis of intermittent broncho spasm of an industrial nature. The physician reiterated the Claimant's employment with Pacific did not aggravate, accelerate or precipitate Mr. Torres' symptoms.

For the reasons stated above, I find Mr. Torres has not proven by a preponderance of the evidence that he sustained an injury arising out of and in the course of his employment with Continental. The preponderance of the evidence indicates the Claimant suffers from tachycardia of a nonoccupational origin and may also suffer from some psychological or psychiatric problems which have not been attributed to the Claimant's employment as a painter. In the absence of a work-related injury, I also find Mr. Torres has sustained no disability within the meaning of the LHWCA. In view of the foregoing, the remaining disputed issues are moot and shall not be discussed herein.

ORDER

It is hereby ORDERED that Cesar Torres' claim for compensation benefits under the Act is DENIED.

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JOSEPH E. KANE
Administrative Law Judge